WHITE RIVER HEALTH SYSTEM

2005 White Drive Batesville, AR 72501
Office Phone: 870-612-2035

UACCB

Thank you for choosing WRHS/UACCB Counseling Program.

_____ has an appointment with

_____ on

_____.

In order for us to provide quality care in a timely manner, we request that you complete this packet before your appointment and bring with you. Our address is 2005 White Drive, Batesville, AR 72501.

Our office number is 870-612-2035

Your cooperation is greatly appreciated. Please call our office if you have any questions. Thank you for choosing WRHS/UACCB Counseling Program.

PATIENT INFORMATION SHEET

Patient's Name _____ Date of Birth _____

Address _____ City, State & Zip _____

Patient's SS # _____ Cell Phone # _____ Home _____

Sex: M F Race: _____, Declined Ethnicity: Hispanic, Non- Hispanic or Declined

Preferred Gender Identity: M F Other: _____

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____

Primary Language _____ Religion _____ Email _____

Would you like to sign for our patient portal? Y N

Appointment reminder: No Reminder Email Voice call Text

Preferred Communication: Email Portal Mail Cell Home Work Text

Primary Language _____ Religion _____

Employer _____ Work Phone # _____

Employer Address _____

Work Status: Full Time _____ Part Time _____ Retired _____ Unemployed _____

Primary Care Physician _____ Location: _____

Name of Pharmacy and location _____

Name of Primary Insurance Card Holder _____

Name of Insurance _____ ID # _____

Group # _____ (Card Holder) DOB _____ SSN _____

Name of Secondary Insurance Card Holder _____

Name of Insurance _____ ID # _____

Group # _____ (Card Holder) DOB _____ SSN _____

Emergency Contact _____ Relationship to Patient _____

Phone # _____ Address _____

How did you hear about this clinic/physician? _____

If Minor- Information of Parent or Guardian

Name (Mom) _____ Primary Phone # _____

Address _____ City, State & Zip _____

Date of Birth _____ Social Security # _____

Employer Name & Address _____

Name (Dad) _____ Primary Phone # _____

Address _____ City, State & Zip _____

Date of Birth _____ Social Security # _____

Employer Name & Address _____

Signed _____ Date _____

Clinic Policy for Confidentiality

PLEASE READ CAREFULLLY AND KEEP FOR FUTURE REFERENCE

Confidentiality Agreement

All interactions which take place in the setting of therapy are considered confidential. This includes requests by telephone, all interactions with this counselor, any scheduling or appointment notes, all session content records and any progress notes that I take during your sessions. I will not even verify that you are a client. You may choose to give me permission in writing to release any or specific information about you to any person or agency that you designate.

Limits to this agreement

1. In some legal proceedings a judge may issue a court order. This would require this counselor to testify in court.

2. If I learn of or believe that there is physical or sexual abuse or neglect of any person under 18 years of age, I must report this information to county child protection services.

3. If I learn of or believe that an elderly person, or disabled person is being abused or neglected, I must file a report with the appropriate state agency that handles elder abuse.

4. If I learn of or believe that you are threatening serious harm to another person, I am obligated to report this. This can be in the form of telling the person who you have threatened, contacting the police or placing you into hospitalization.

5. If there is evidence that you are a danger to yourself and I believe that you are likely to kill yourself unless protective measure are taken, I may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection

6. There may be times when I consult with outside sources about cases. In these cases, no personally identifiable information will be used to discuss this case. However, discussion topics will be used in order to ensure that I am getting and giving the best assistance possible. The persons with whom I discuss cases are legally bound to keep information confidential.

_____ _____

Client Signature Date

Emergency Care Policy

WRHS counseling office at UACCB is open Monday through Friday 8:00 a.m. to 5:00 p.m. We are closed on weekends and most holidays. Please call our office for non-emergency issues during our business hours. **If you have an emergency, please go directly to the nearest emergency room or call 911.**

Our office does not provide coverage for provider absences due to illness, vacation, or personal emergency. Every effort will be made to keep you informed/notified of schedule changes in a timely manner.

_____ _____

Client signature Date

No Show Policy

We reserve this time specifically for you and we will be unable to offer this time to someone else in a timely manner. Repeated no shows may result in termination and referral of your provider/patient relationship. Please call 24 hours before if unable to make the appointment.

_____ _____

Client Signature Date

CONSENT FOR TREATMENT ACKNOLODGEMENT OF RECEIPT OF OFFICE POLICIES

I understand and agree to the following as evidenced by my initials:

1. _____ Confidentiality Form
2. _____ Emergency Care Policy
3. _____ No Show Policy

By my signature below, I hereby authorize treatment from WRHS/UACCB Counseling Clinic and its providers. I acknowledge that I have received a copy of the White River Health Systems Notice of Privacy Practices.

_____

(Name) (Date)

Consent to treat: I voluntarily consent to receive medical and health care services - these services may include diagnostic procedures, examinations, blood work and treatment.

Authorization to release insurance information: I hereby authorize release of medical information to give my insurance company or company's any insurance information they require concerning my case.
Authorization for Assignment of medical payments: I hereby authorize payment of any medical benefits to WRHS Behavioral Health Clinic.
The undersigned herby authorizes White River Medical Center and the attending or consulting physician to photograph or permit other person to photograph while under the care of the above medical organization, and agree that they may use or permit other persons to use the negative, prints, digital, and/or video prepared there for such purposes and in such a manner as may be deemed necessary to provide medical care. _____
Use of picture declined _____
Authorization to Access Rx History Information: I hereby authorize WRHS Behavioral Health Clinic to access my historical prescription drug information
___ Yes ___ Declined
I have received a copy of the notice of privacy practices written acknowledgement form.

_____ _____ Date:_____
Signature of Patient or Personal Representative Relationship to Patient (parent, spouse, self)

Patient Name:_____

Contact Preferences

Please fill in circle for preferred contact method

- O Home Phone ( ) _____
- O Cell Phone ( ) _____
- O Work Phone ( ) _____
- O E-Mail ( ) _____

Please indicate by check mark your approval to leave the following information on voicemail:

- O Appointment Date and Time Reminder
- O Lab/Test Results/ Medication Changes
- O DO NOT LEAVE MESSAGES OF ANY KIND

The following people are allowed to receive information regarding my care and/or have my permission to consent for care of my child.

_____
Name and Relationship to Patient

_____
Name and Relationship to Patient

_____
Name and Relationship to Patient

_____
Name and Relationship to Patient

For Office Use Only

_____ _____ _____
Witness MRN Date of Signing

INTAKE DATA (PLEASE COMPLETE ALL PAGES)

Name: _____ DOB: _____

Home phone number: _____ Work: _____

Can we contact you at home if needed? _____ Yes _____ No

Can we leave a message for you if someone else picks up the phone, or if there is an answering machine? _____ Yes _____ No

Can we contact you at work? _____ Yes _____ No

Can we leave a message for you at work? _____ Yes _____ No

Who referred you to the clinic? _____

Name of Primary Care Physician: _____

What are your reasons for making an appointment (WE DO NOT SEE COURT ORDER PATIENTS)? _____

Do you have thoughts of self harm/suicide or thoughts of harming someone else? _____

Have you ever taken any action on these thoughts? _____

If yes, please explain _____

Past Medical History (please circle all that apply):

AIDS/HIV
Allergies
Arteriosclerosis (artery disease)
Arthritis
Blood Disorder
Brain Disease or infection
Cancer or chemotherapy
Chronic Pain
Concussion
Dementia
Diabetes
Head Injury
Heart Disease
Huntington's Disease
Hypertension
Kidney Disease
Loss of Consciousness
Lung (respiratory) disease
Meningitis
Multiple Sclerosis
Obesity
Parkinson's Disease
Seizure Disorder

Other Past Medical History Not Listed Above: _____

DRUG ALLERGIES _____

Currently prescribed and medications (list name and dosage):

Current over the counter medications, vitamins or health food supplements you take (list name and dosage): _____

_____

_____

Do you have chronic pain?_____Yes_____No (Answer the ** questions only if you have chronic pain)

**Where is your pain located?_____

**Have you been given a diagnosis and treatment plan for your pain? If so, please describe:_____

_____

**What are your expectations for pain relief?_____

_____

**Rate your pain on a 0-10 scale (0=no pain; 10=worst pain imaginable):

Current:_____ Highest:_____ Lowest:_____ Average:_____

**What helps your pain?_____

_____

**What makes your pain worse?_____

_____

**What treatments have you had for your pain and did they work?_____

_____

Psychiatric History:

Are you currently in psychotherapy or under psychiatric care?_____Yes_____No

Have you ever been seen by a psychologist, psychiatrist, counselor, or therapist for a mental health condition?_____Yes_____No

If yes, why, where, when, and how long?_____

_____

Past Psychiatric Medications:_____

_____

_____

_____

Past Psychiatric Hospitalizations (when, where, how long, psychiatrist's name):

_____

_____

_____

_____

Have you had a prior psychological evaluation or neuropsychological evaluation?

_____Yes-if Yes, please list the provider_____

_____No

Have you ever been diagnosed with the following conditions? (check all that apply

__Schizophrenia

__Depression

__ Mental Retardation

__ Anxiety

__ Explosive Disorder
__ Learning Disability
__ Bipolar (Manic Depressive Disorder)
__ Multiple Personality Disorder/ Dissociative Disorder
__ Other (please specify):

__ Obsessive-Compulsive Disorder
__ Anorexia/Bulimia
__ Borderline Personality Disorder
__ Antisocial Personality Disorder
__ Post Traumatic Stress Disorder

Comments:

Do you presently have depression? ____ Yes, ____ No
If yes, how long and describe:

Describe any past depression:

Do you presently have anxiety/nervousness? ____ Yes, ____ No
If yes, how long and describe:

Is your sleep: ____ good, ____ fair, ____ poor (How many hours per night? ____)
Is your appetite: ____ good, ____ fair, ____ poor
Have you: ____ lost some weight, ____ gained some weight. If so, how much and in what period of time?
Is your energy: ____ good, ____ fair, ____ poor? Since when?
Please list any mental illness or alcohol/drug abuse in the family:

Please list any psychiatric problems in your family:

Has anything happened recently to change your situation?	____ Yes, ____ No
Are you a "hyper" person who worries about everything?	____ Yes, ____ No
Do you have a depressed mood?	____ Yes, ____ No
Do you have problems doing everyday chores/activities?	____ Yes, ____ No
Have you lost interest in your normal activities?	____ Yes, ____ No
Do you have a loss of feelings for relatives or friends?	____ Yes, ____ No
Do you have problems with memory or concentration?	____ Yes, ____ No
Do you have long-term feelings of guilt or low self-worth?	____ Yes, ____ No
Are you thinking worse and worse about the future?	____ Yes, ____ No
Do you sometimes feel as if you would be better off dead?	____ Yes, ____ No
Does suicide seem like a better solution to you at times?	____ Yes, ____ No
Have you ever had thoughts or plans of death or suicide?	____ Yes, ____ No
Have you ever attempted suicide?	____ Yes, ____ No

If yes, please explain:

Do you feel empty inside? ____ Yes, ____ No
Are you bored most of the time? ____ Yes, ____ No
Do you or have you ever cut or harmed yourself on purpose? ____ Yes, ____ No
Have you ever hurt other people because you are angry with them? ____ Yes, ____ No
Would you reveal to us your plans to hurt yourself or others? ____ Yes, ____ No
Do you or have you ever had any fits and lost control? ____ Yes, ____ No
Have you had multiple, intense, full of conflict relationships? ____ Yes, ____ No
Do you feel people are either good or bad with no in-between? ____ Yes, ____ No
Are you angry most of the time? ____ Yes, ____ No
Do you hear voices that other people don't hear? ____ Yes, ____ No
Do you have visions (see things that other people don't see)? ____ Yes, ____ No
Do you think that some people, thing or group is out to get you? ____ Yes, ____ No
Does your imagination play tricks on you? ____ Yes, ____ No
Does it seem as if someone/something is controlling your thoughts? ____ Yes, ____ No
Do you feel that you can read people's minds? ____ Yes, ____ No
Have you ever gone more than a couple days without sleeping? ____ Yes, ____ No
Have you experienced a traumatic event that still impacts you? ____ Yes, ____ No

Substance Use History:

I began drinking alcohol regularly at age:

_____Prior to age 10 _____10-15 _____16-18 _____19-21 _____over 21

I drink alcohol:

_____Rarely or never _____1-2 days/week _____3-5 days/week _____Daily

The usual number of drinks I have at one time:_____

My last drink was: _____

I used to drink alcohol but have stopped:_____ Date stopped:_____

I used to drink excessively: Yes No

Check all that apply:

_____I can drink more than most people my age and size before I get drunk.

_____I sometimes get into trouble (e.g. fights, legal problems, conflicts, problems at work, accidents, etc) after drinking.

_____I sometimes black out after drinking.

_____I have had legal problems associated with drinking.

_____I have been in alcohol treatment: _____Past _____Current

Drug Use: ___ past ___ current ___never

Please check all of the drugs you are now using or have used in the past:

	Presently Using	Used in Past	Age used
Amphetamines (including diet pills)			
Barbiturates (downers, etc.)			
Cocaine or Crack			
Hallucinogenics (LSD, acid, etc.)			
Inhalants (glue, nitrous oxide, etc.)			
Marijuana			
Methamphetamines			
Opiate Narcotics (heroin, morphine, etc.)			
PCP (angel dust)			

Other drugs_____

Do you consider yourself to be dependent on any of the above substances?

_____Yes _____No

Do you consider yourself to be dependent on any prescription medications?

_____Yes _____No

Have you had any drug or alcohol treatment? ___ past ___ current ___ never

Do you smoke?_____No _____Yes, amount per day_____

Do you drink caffeine?_____No_____Yes, amount per day_____

Legal History:

Have you been court ordered to receive psychiatric treatment? ___ Yes ___ No

Are you seeking Workman's Compensation? ___Yes ___No

Are you applying for Disability (SSI or SSDI)? ___ Yes ___No

Have you ever been to jail, prison or on probation? ___ Yes ___No

If yes, please explain:

_____

_____

_____

Are you presently in any legal trouble? ___ Yes ___No

If yes, please explain:_____

_____

_____

Do you own a weapon? ___ Yes ___ No

If yes, please explain what type(s) and how many:_____

_____

Social History:

Marital Status:___Single ___Married ___Partnered ___Divorced ___Widowed

How many times have you been married?_____

How long each marriage? 1st_____ 2nd_____ 3rd_____

How many children do you have?_____What are their ages?_____

Highest grade or degree you have earned:_____

How would you describe your performance as a student? (Please circle)

As/Bs Bs/Cs Cs/Ds Ds/Fs

Current job title:_____Spouse job title:_____

How long have you been at this job?_____

Prior jobs:_____

Have you ever been abused? _____ physically, _____ sexually, _____ psychologically

If so, at what age(s)? _____

What do you like to do in your spare time?_____

_____

Have you ever been in the military? _____Yes _____No

If yes, Branch_____Type of Discharge_____

Major duties in military:_____

_____

Please add any helpful comments: _____

Do you have any questions at this moment? _____

_____

Patient Signature

_____

Date

REVIEW OF SYSTEMS

Patient Name: _____ Date: _____

Place check (✔) if present

Constitutional
- _____ Chills or fever
- _____ Fainting spells
- _____ Night sweats
- _____ Swollen glands
- _____ Weight gain
- _____ Weight loss
- _____ Other

Skin
- _____ Change in moles
- _____ Itching
- _____ Psoriasis
- _____ Rashes
- _____ Bumps
- _____ Other

Head (HEENT)
- _____ Cataracts
- _____ Double Vision
- _____ Glaucoma
- _____ Headaches
- _____ Hearing Loss
- _____ Ringing in ears
- _____ Wear hearing aid

- _____ Bleeding gums
- _____ Dentures
- _____ Loose teeth
- _____ Removal bridge
- _____ Frequent colds
- _____ Nosebleeds
- _____ Persistent hoarseness
- _____ Sore throat

Cardiovascular
- _____ Artificial valve
- _____ Chest Pain
- _____ Fainting spells
- _____ Heart attack in past
- _____ Heart disease
- _____ Heart murmur
- _____ High blood pressure
- _____ High cholesterol
- _____ Irregular heartbeat
- _____ Mitral valve prolapse
- _____ Pacemaker
- _____ Rheumatic fever (hx)
- _____ Swollen ankles

Respiratory
- _____ Asthma or wheezing
- _____ Can't breathe when flat
- _____ Chest colds
- _____ Cough up blood
- _____ Frequent cough
- _____ Shortness of breath
- _____ Other

Gastrointestinal
- _____ Abdominal pain
- _____ Appetite loss
- _____ Blood/tarry stools/bleeding
- _____ Changes in bowel habits
- _____ Colon cancer in past
- _____ Constipation/diarrhea
- _____ Nausea/vomiting
- _____ Frequent heartburn
- _____ Gallbladder trouble/ulcers
- _____ Hemorrhoids
- _____ Hiatal hernia
- _____ Jaundice/liver trouble
- _____ Swallowing difficulty

Exposure to:
- _____ Gonorrhea
- _____ Herpes
- _____ AIDS
- _____ Syphilis
- _____ Hepatitis
- _____ Blood trans.
- _____ TB

Genitourinary
- _____ Bladder control prob.
- _____ Blood in urine
- _____ Frequent urination
- _____ Kidney disease
- _____ Night urination
- _____ Painful urination
- _____ Stones
- _____ Other

(Men Only)
- _____ Discharge - penis
- _____ Erection problems
- _____ Impotence
- _____ Lump in testicles
- _____ Other

(Women Only)
- _____ Breast lump or mass
- _____ Change in periods
- _____ Discharge - nipple
- _____ Endometriosis
- _____ Hot flashes
- _____ Menopause
- _____ Painful periods
- _____ Vaginal discharge

Endocrine
- _____ Diabetes
- _____ Excessive thirst
- _____ Fatigue
- _____ Swollen glands
- _____ Intol to heat or cold

Musculoskeletal
- _____ Arthritis
- _____ Back pain
- _____ Muscle cramps
- _____ Muscle weakness
- _____ Numbness/tingling
- _____ Walking problems
- _____ Other

Neurological
- _____ Dizzy spells
- _____ Headaches
- _____ Memory loss
- _____ Paralysis
- _____ Seizure/epilepsy
- _____ Shakiness/weakness
- _____ Stroke
- _____ Other

Psychological
- _____ Anxious
- _____ Depression
- _____ Family problems
- _____ Fatigue
- _____ Insomnia
- _____ Marital problems
- _____ Stress
- _____ Other

Accidents or Injuries

_____
Patient Signature